**Hebert (HB 2268)** **Act No. 1188**

New law provides that a health care provider, except as otherwise prohibited by state or federal law, may bill an insured, enrollee, or subscriber for payment of the balance of a bill for care rendered by that provider and not paid or covered by health benefits only if the health care provider has notified such insured, enrollee, or subscriber prior to rendering such care that he may be liable for such payment. Requires that an insured, enrollee, or subscriber be allowed a grace period of at least 25 days from the date of billing to remit payment of any such balance bill.

Existing law requires every hospital, health, or medical expense insurance policy, hospital or medical service contract, employee welfare benefit plan, health and accident insurance policy, any policy of group, family group, blanket or franchise health and accident insurance, self-insurance plan, health maintenance organization, and preferred provider organization in this state to provide benefits for anesthesia rendered in a hospital setting and for associated hospital charges when the mental or physical condition of the insured requires dental treatment to be rendered in a hospital setting. Authorizes such health insurers to require prior authorization for such hospitalization and to restrict coverage to procedures performed by dentists meeting certain qualifications. Also requires dentists to consider certain utilization standards of the American Academy of Pediatric Dentistry in determining whether the procedure needed to treat a particular condition under general anesthesia is appropriate. Specifically excludes treatment rendered for temporal mandibular joint (TMJ) disorders and does not apply to certain individually underwritten and limited benefit policies.

New law makes existing law applicable to the State Employees Group Benefits Program.

Effective August 15, 1999.

(Amends R.S. 22:228.7(A); Adds R.S. 22:230.3)